Forensic Special Populations Work Group

Report to the Restructuring Policy Advisory Committee

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Department of Mental Health, Mental Retardation and Substance Abuse Services

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- Virginia Sheriffs Association
- Virginia Association of Regional Jails
- Virginia Department of Corrections
- Virginia Dept. of Criminal Justice Services
- The Office of the Executive Secretary of the Supreme Court of Virginia
- Virginia Department of Mental Health Mental Retardation & Substance Abuse Services
- NAMI Virginia
- NAMI-Northern Virginia
- Commonwealth's Attorneys Service Council
- Public Defenders Commission
- The University of Virginia Institute of Law, Psychiatry and Public Policy
- Office of the Attorney General of Virginia
- Virginia Municipal League
- Virginia Association of Counties
- Virginia Hospital and Healthcare Association
- Virginia Division of Legislative Services
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Executive Summary: Forensic Special Populations Work Group Report

In the fall of 2003, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) convened the Forensic Special Populations Work Group. This work group was established to analyze current approaches to mental health and substance abuse services delivery to the population of consumers having collateral involvement with the criminal justice system. This group of individuals, often referred to as "forensic patients" in facility settings, has long been considered to present a unique set of treatment challenges, partly due to their being under the jurisdiction of the courts, and because mental health and substance abuse treatment of forensic clientele must often be conducted in secure settings.

Key factors in current system were identified:

- The demand for forensic hospital beds typically exceeds the supply.
- There are no dedicated community-based alternative treatment sites for acute treatment or restoration to competency services for this population.
- Jails have a bona fide obligation to provide psychiatric care to consenting inmates needing such medical treatment**.**
- Jail inmates in need of involuntary medication treatment cannot be treated in jails.
- Restoration to competency to stand trial treatment is outside the legal bounds for law enforcement (jails) to provide, although jails may be appropriate sites for the provision of community-based competency restoration by other providers.
- CSBs are not currently structured or equipped/do not have sufficient current resources to provide dedicated MH/SA treatment services to offenders in custody.
- The provision of forensic mental health and substance abuse services in jail settings constitutes a complex matter that requires the cooperation of many civil, law enforcement, local, state, and organizational entities to effectively implement.

The unique level of collaborative engagement characterizing this work group has yielded a solid consensus regarding the range of best approaches for reaching the overall goals of this project. Although the work group membership has struggled with sometimes varying views of the problems to be confronted in preventing the so-called "criminalization" of those with serious mental illness, there has been agreement that, with some exceptions, the law of the Commonwealth does not necessarily exclude individuals with mental illness from criminal prosecution in an a priori manner. While recognizing that reality, the work group membership has agreed that law enforcement and the courts have a crucial role to play, along with that of the defendant and his or her representatives, in the identification of those with mental illness and substance abuse disorders for whom diversion from arrest or prosecution or jail confinement is an appropriate dispositional option. The following statement and recommendations summarize the consensus position of the Forensic Special Populations Work Group:

General Recommendations of the Forensic Special Populations Work Group:

1. Establish the following goals for the provision of community-based mental health services to individuals in the criminal justice system with serious mental illness:

    a. Minimize the number of non-violent individuals with mental illness or serious substance abuse disorders in the criminal justice system

   b. Enhance the delivery of mental health services to incarcerated individuals, both to reduce demand for hospitalization and to prevent re-hospitalization of individuals returned to incarceration following inpatient treatment & evaluation
   c. Provide access to hospital care, when appropriate, with minimum delays, so that the resulting length of hospitalization may be reduced, and the management of mentally ill individuals in the jail may be enhanced.
   d. Require appropriate cross-training for key players in both the mental health and criminal justice services communities.
   e. Provide adequate resources to localities, so that required systems changes can be implemented.

2. Continue to respond to the mandates of SJR 81, of the 2004 General Assembly, and related budget language requiring the DMHMRSAS to develop a web-based program for the sharing of innovative practices for the treatment of individuals with mental illness and substance abuse treatment needs, and to continue the activities of this work group. (Although the DMHMRSAS has recently implemented a web-based program of this type, additional follow-through work is needed in this area.)
3. Devote additional study and analysis to the issue of substance abuse among the offender population. Substance abuse constitutes a key or overriding problem faced by all of the populations targeted by the work group agenda.
4. Support implementation of the plan of recommended actions that has been submitted by the Juvenile Justice Subcommittee of the Child and Adolescent Special Populations Work Group.
5. Through budgetary language and funding initiatives with the Virginia General Assembly, complete the following actions:
   a. Develop a model Community Policing curriculum for Crisis Intervention Training for law enforcement officers in all jurisdictions of the Commonwealth.
   b. Support in language and with resources the improved access of the courts in Virginia to the services of expert mental health evaluators.
   c. Direct the implementation of, and provide sufficient resources to develop a statewide cross-training program, developed through the DCJS, in all relevant areas of mental health and substance abuse assessment and treatment, geared toward law enforcement, jail personnel, court personnel, and mental health personnel having involvement with service delivery in the criminal justice system.
   d. Direct the development of, and provide resources for implementing a joint VACSB/DMHMRSAS/law enforcement information sharing system.
   e. Endorse and direct the provision of renewable resources for the continuation of those model Virginia programs that are currently funded by temporary federal grants, or do not have a specified funding stream, such as the Montgomery County Crisis Intervention (CIT) program, the Chesterfield Day Reporting Center, and the Norfolk Mental Health Court.
   f. Direct the DMHMRSAS and the Virginia CSBs to implement the community-based Restoration to Competency To Stand Trial program that has recently been developed on a statewide basis. Provide sufficient funding and other needed resources for each CSB to accomplish this goal.
   g. Provide resources and budget language to develop pilot jail MH and SA services programs, based upon evidence-based approaches, for at least 3 Virginia jails.

h. Using a pilot program approach, provide resources and directives necessary for the development of additional mental health courts in the Commonwealth.
i. Provide resources necessary to develop the means for the Department of Corrections, the DCJS, the Virginia Board of Compensation, and local and regional jails, in conjunction with the DMHMRSAS, to accurately depict the current population of inmates having serious medical illnesses, mental illness and substance abuse disorders in local, regional and state correctional facilities, and under the supervision of DOC Community Corrections and local offices of probation and parole.
j. Allocate sufficient resources and provide directives to develop a statewide, multi-agency approach toward planning and providing a model pharmacy and drug formulary program that will ensure the use of "best practices" in selecting the range and types of medication to be used by medical providers in the jails and prisons of the Commonwealth.
k. Provide for the allocation of DMHMRSAS resources for the maintenance and upgrading of the Forensic Information Management System (FIMS).
l. Provide language and resources to ensure that there is an adequately trained group of forensic mental health evaluators available throughout the state to conduct court-ordered evaluations on an outpatient basis.
m. Direct and denote resources for the implementation by the DMHMRSAS of a comprehensive program for training mental health and criminal justice professionals and others in evidence-based, "best practices" approaches to the provision of community-based and facility-based mental health and substance abuse treatment modalities for individuals with criminal justice system involvement.

6. Change Virginia Medicaid regulations in the following ways: Provide for "suspension", rather than "termination" of Medicaid benefits to recipients who are incarcerated in local and regional jails. Alter Virginia Medicaid regulations to provide for reimbursement to providers of Substance Abuse treatment services to Medicaid recipients.
7. Endorsement of the concept of designation of community psychiatric facilities as proper treatment sites for nonviolent criminal defendants in need of acute care.
8. Promote the successful adoption of the recommended changes requested of the Office of the Executive Secretary of the Supreme Court of Virginia (OESSCV) by DMHMRSAS Commissioner Reinhard, regarding forensic evaluations services, in his letter of July 6, 2004 to Secretary Baldwin.
9. Continue to develop procedures for DMHMRSAS psychiatric hospitals to complete outpatient evaluations for the courts, and continue to work with the criminal courts to divert evaluations to community providers, wherever appropriate.
10. Encourage the review and appropriate modification of DMHMRSAS inpatient programs for individuals found "Not Guilty by Reason of Insanity (NGRI)" or "Unrestorably Incompetent to Stand Trial (URIST)", as well as "mandatory parolees".
11. Consult with the Virginia Board of Corrections regarding the need to expand upon the current mental health standards set by that body for local and regional jails, in *Virginia Administrative Code* § 6VAC15-40-1010.
12. Integrate the activities of the Governor's NGA Policy Team for Prisoner Reentry with this work group process, as feasible.
13. Continue to identify and recommend all necessary changes in these areas that shall be required to implement each programmatic goal of the work group: Funding/resource allocation needs; local/state policy changes; memoranda of agreement for designated activities; changes in the *Code of Virginia*, or *Virginia Administrative Code*; licensure/certification procedures needed; human rights procedural guarantees.

Forensic Special Populations Work Group

Report to the Restructuring Policy Advisory Committee

Introduction

The Forensic Special Populations work group was developed out of Governor Warner's 2003 Community Reinvestment and Restructuring Initiative for mental health, mental retardation and substance abuse services. That initiative was based upon a 30-year history of community-focused efforts in the Commonwealth, aimed at improving the availability and quality of mental health care for Virginia residents. The aim of the Reinvestment Initiative has been to develop a statewide system of community-based services for citizens who require mental health and substance abuse treatment of all types. Decreased reliance on facility-based care has been the goal and hallmark of the Governor's initiative. The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) has made use of planning with community partners for developing innovative approaches to service provision in the Commonwealth, as part of the Reinvestment and Restructuring agenda.

The DMHMRSAS convened 5 separate work groups, as part of the Reinvestment and Restructuring Initiative. This was done to provide separate forums for review of the needs of various consumer subgroups in our service realm. The 5 Special Populations work groups are: Mental Retardation; Geriatrics; Child and Adolescent; Substance Abuse; Forensic. The Forensic Special Populations Work Group was convened by the DMHMRSAS in order to develop a set of recommended changes to the current system of care that is available to those Virginia residents having mental health, mental retardation and substance abuse treatment needs who also fall under the aegis of the criminal justice system. This group of consumers, often referred to as "forensic" consumers, is considered to present a unique set of treatment needs that crosses traditional service delivery boundaries in many instances. The provision of treatment services to forensic consumers must also occur in a manner that is consistent with their status as individuals who are under the direct jurisdiction of the criminal courts, and who often require treatment in a secure setting.

The general format followed by of the forensic special populations work group is outlined below.

Forensic Special Populations Work Group Primary Directives:

1. Review the approaches that are currently in place, statewide, for the evaluation and treatment of individuals (both adults and juveniles) with MH and SA disorders having criminal justice system involvement.
2. Consider state-of-the-art, innovative, "evidence-based" approaches to treatment with this group.
3. Develop consensus among all of the relevant constituent groups, with regard to areas needing change in the current service delivery system.
4. Formulate recommendations for Restructuring Policy Advisory Committee.
5. Outline the best approach, or set of approaches needed to best accomplish recommended changes to the current system of care.

Work Group Tasks

From the outset of the group process, the group has focused on ways to assess unmet need for additional or modified service provision, upon identifying the approach or combination of approaches that best addresses the need for enhanced, timely service access, and the "how to" issues of practical implementation of any recommended interventions.

The work group has also worked to identify and set priorities for recommended program changes, and to determine activities that must be accomplished, such as: Changes in statute or state regulation, state agency and/or local policies, budgetary requests and allocations, Memorandums of Agreement (MOAs), licensure, etc. It has also been the goal of the group to integrate findings into a comprehensive report to the Policy Advisory Committee

Forensic Work Group Goals:

The forensic work group also identified several goals for its mission:

- The prevention of unnecessary arrest, incarceration and prosecution of mentally ill citizens and those with co-occurring or serious substance abuse disorders is the principal and most important goal of the project.
- Determining routes to ensure the enhanced availability of community-based evaluation and treatment services, in lieu of state hospital treatment.
- Identifying approaches to the reduction of prolonged wait times for admissions to state MH facilities that are necessary for clinical reasons.
- Developing a general model for the appropriate provision of mental health services within local correctional settings.
- Consideration of possible modifications to the policies and procedures employed in state facilities for the treatment of long-term forensic patients.
- Implementing the directives of SJR 97/HJR 142 and the Behavioral Health Care Subcommittee of the JCHC, to the extent that doing so is feasible.
- Address issues related to the reentry of Virginia Department of Corrections inmates having mental illness, mental retardation or substance abuse disorders to the community, and the needs of this group of consumers for access to appropriate treatment services.

The work group initially addressed the following overview matters:

- The respective roles of each representative in the forensic MH treatment process and in the process of developing and implementing change.
- Developing and verifying an initial consensus regarding the problem of criminal justice system involvement of the mentally ill, and the operational/procedural challenges that are embedded in the current service delivery model.

Key factors in current system were identified:

- The demand for forensic hospital beds typically exceeds the supply, on any given day.
- There are no dedicated community-based alternative treatment sites for acute treatment or restoration to competency services for this population.
- Jails have a bona fide obligation to provide psychiatric care to consenting inmates needing such medical treatment**.**
- Jail inmates in need of involuntary medication treatment cannot be treated in jail settings.
- Restoration to competency to stand trial treatment is outside the legal bounds for law enforcement (jails) to provide, although jails may be appropriate sites for the provision of ("outpatient") competency restoration by other providers.
- CSBs are not currently structured or equipped/do not have sufficient current resources to provide dedicated MH/SA treatment services to offenders in custody.
- The provision of forensic mental health and substance abuse services in jail settings constitutes a complex matter that requires the cooperation of many civil, law enforcement, local, state, and organizational entities to effectively implement.
- While there is much agreement about the needs of offenders with mental illness and serious substance abuse disorders among the stakeholder group, achieving final consensus about the proper set of solutions to the challenges in this area shall require careful and comprehensive negotiation.
- There is currently a lack of adequate resources to allow for continuance of the current approaches without continuing to also perpetuate current problems with delays in access to treatment services, lack of appropriate continuity of care procedures, and the implementation/provision of community-based preventive and follow-up treatments.

Work Group Activities

During the FY 2004 tenure of the work group, the membership became familiarized with the wealth of information and data that has been developed on a national level, related to the treatment needs of individuals having mental illness and substance abuse disorders who are under the active aegis of the criminal justice system. Among the key resources studied for this project were:

- The Criminal Justice/Mental Health Consensus Project report, published by the Council of State Governments (2002);
- The body of work on jail diversion, mental health courts, and jail mental health services that has been authored by Policy Research Associates and its affiliates, during the past several years;
- Reports produced by the DMHMRSAS and other agencies for the SJR 440/SJR 97 Committee Studying Treatment Options for Offenders with Mental Illness and Substance Abuse Disorders;
- The recent work of other national advocacy organizations, such as the National Alliance for the Mentally Ill, the Bazelon Center, the NASMHPD, the National Mental Health Association, and the American Psychiatric Association;
- DMHMRSAS regulations and Performance Contract information related to treatment of this population;
- Jail Mental Health standards published by the Department of Corrections

- Information provided by the Virginia Compensation Board, related to jail programs and services
- Summaries provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) of emerging best practices in the areas of pretrial jail diversion and mental health courts programs that have been funded by that agency.
- Information from multiple sources, including the National Governors' Association and the Urban Institute, regarding innovative practices in the area of mental health and substance abuse service needs and programs for state prisoners who are returning to community residence.
- The Statement of Principles, developed by Dr. Hafemeister of the ILPPP as a conceptual basis for the work group's activities was reviewed and discussed.

During the course of the work group meetings, a portion of each meeting has been devoted to reviews of current or proposed practices in forensic mental health around the state. Some of these activities and presentations have included:

1. Review of Virginia statutory basis for provision of MH/SA services to offenders in local and regional correctional centers, community settings and state hospitals

2. Review of model/promising Virginia programs aimed at diverting individuals from jail:

    - New River Valley Crisis Intervention Team
    - Chesterfield County Day Reporting Center
    - Norfolk Mental Health Court
    - The Jail MH Services Team that is soon to become operational in HPR IV

3. Review of model/promising Virginia programs aimed at improving MH/SA service delivery to jail inmates

    - Henrico County Jail programs:
        - Mental Health jail-based services
        - Social Recovery model SA jail treatment program
        - Diversion of nonviolent mentally ill inmates to community psychiatric hospitals
    - Arlington County Jail program: Innovative provision of full array of MH services
    - Fairfax County Jail program:
        - Jail-based SA therapeutic communities
        - Jail-based MH treatment services

4. Discussion of the judicial perspective on need for and access to forensic MH/SA treatments

In addition to the aforementioned review of current national innovations in jail diversion and forensic mental health service delivery, and the review of current local programs, the primary vehicle to enlightenment regarding the problems and prospects for the Virginia system of care for this population has been the extraordinary process of sharing of relevant information, by each of the work group members, about the current programs and activities with which they are

associated. Along with the high degree of insight and dedication brought to the work group process by each member, this exchange of information by the members has been the key element in the group's generative and productive success, to date.

General Conclusion and Position Statements

The unique level of collaborative engagement characterizing this work group has yielded a solid consensus regarding the range of best approaches for reaching the overall goals of this project. Although the work group membership has struggled with sometimes varying views of the problems to be confronted in preventing the so-called "criminalization" of those with serious mental illness, there has been agreement that, with some exceptions, the law of the Commonwealth does not necessarily exclude individuals with mental illness from criminal prosecution in an a priori manner. While recognizing that reality, the work group membership has agreed that law enforcement and the courts have a crucial role to play, along with that of the defendant and his or her representatives, in the identification of those with mental illness and substance abuse disorders for whom diversion from arrest or prosecution or jail confinement is an appropriate dispositional option. The following statement and recommendations summarize the consensus position of the Forensic Special Populations Work Group:

The provision of community-based mental health services to those with serious mental illness should be geared to the following goals:

a. **Minimizing the number of non-violent individuals with mental illness or serious substance abuse disorders in the criminal justice system**
b. **Enhancing the delivery of mental health services to incarcerated individuals, both to reduce demand for hospitalization and to prevent re-hospitalization of individuals returned to incarceration following inpatient treatment & evaluation**
c. **Providing access to hospital care, when appropriate, with minimum delays, so that the resulting length of hospitalization may be reduced, and the management of mentally ill individuals in the jail may be enhanced.**

The particular problem areas relevant to the population in question will vary from locality to locality. These problems will no doubt require intervention at a number of potential points in the continuum of care, from pre-arrest community mental health through the stages of arrest, booking, incarceration, hospitalization, adjudication and community re-entry.

Key players in both the mental health and criminal justice services communities shall require appropriate cross-training in the concepts, processes and pragmatics which underpin each discipline, in order for the changes recommended here to take proper hold. Additionally, adequate resources shall need to be in place in most localities, before changes to the current system can even begin to be planned for, in some instances.

In accord with the endorsement provided to this work group by the provisions of *Senate Joint Resolution # 81*, of the 2004 session of the Virginia General Assembly, this work group should continue to serve as a primary interagency mechanism for the development of an approved system of treatment services for offenders having mental illness and substance abuse disorders.

Proposed General Treatment Model for Individuals having concurrent Mental Health and/or Substance Abuse Treatment Needs, and Criminal Justice System Involvement

I: <u>Community-based Prevention, Early Intervention and Pre-booking Diversion</u>: Diversion from arrest and incarceration of persons with serious mental illness and substance abuse disorders should be a primary focus of intervention with the target population. Reduction in community mental health services increases the number of mental health consumers who encounter the criminal justice system. Pre-booking Diversion: If arrest is unavoidable, release prior to booking or arraignment is preferable. Individuals with misdemeanor or non-violent offenses who are known consumers of the local community mental health services providers are the typical target population. Models such as the Memphis Crisis Intervention Training (CIT) approach for training police officers in the identification of the target population may be integrated with crisis intervention services as in the New River Valley initiative.

❖ ***Recommended actions:***

1. The Commonwealth of Virginia, through action of the General Assembly and the relevant executive branch agencies, should provide necessary changes to the law and state regulations, and ensure the provision of sufficient resources to enable and require Virginia localities to address this problem in an adequate and expeditious manner.
    a. Provide proper Medicaid or other funding streams to local hospitals for short-term treatment of individuals in this group, through changes to Code or state Medicaid policy and regulations.
    b. Implement, via the GA appropriations process, a statewide, dedicated funding stream targeted specifically to jail diversion programs.
    c. Modernize training requirements and regulations affecting law enforcement and mental health services agencies in a manner that supports the diversion agenda.
2. Community agencies, including local law enforcement, the CSB, the local Department of Social Services, Jail administrators and representatives of the courts should, under the aegis of the Community Criminal Justice Board (CCJB) or other dedicated organizational entity, develop a comprehensive plan, and all necessary Memoranda of Agreement (MOAs), for the prevention of arrest and incarceration of individuals in the target population when they become the focus of law enforcement, due to behaviors that are symptomatic of their disabling conditions, or which occur as a result of the direct impact of their disabling condition upon their social judgment and behavior. Community planning efforts of this type should address the following components, at a minimum:
    a. Recruit the approval and commitment of local governing bodies to the implementation of the prevention program, including the identification of funding streams, in-kind services, etc.
    b. Implement a preventive, community policing-oriented approach for law enforcement that includes cross-training in relevant aspects of mental health assessment and intervention for law enforcement personnel. (The Memphis Crisis Intervention Training program is one model approach that could be applied to this task. There are others, as well.)

c. Cross-train mental health personnel in law enforcement methods. (Resources are readily available for this purpose.)
d. Select an appropriate active and preventive joint crisis intervention program for the target population that is consistent with current evidence-based practices in this area. (There is currently an array of viable police-based and mental health services-based models that may be adopted or modified for this goal.)
e. Secure the involvement of local courts and Commonwealth's and Defense Attorneys in the development of the prevention model. (Cross-training may be needed here, also.)
f. Inclusion of both public and private community providers of MH and SA treatment services in the planning of the prevention program.
g. Provide for the active involvement of consumers and families in all planning efforts.
h. Identify and acquire all component elements, including personnel, equipment, office space, medical, hospital, housing and related services that have been identified as necessary for the success of the program.
    i. Utilize existing MH/SA service components, such as established PACT teams, crisis intervention and stabilization centers, intensive case management services.
    ii. Make use of existing law enforcement initiatives, such as community policing approaches, as a basis for implementing change.
    iii. Involve local consumer advocacy groups, including nonprofit offender services organizations, as well as families of consumers in the planning/implementation process.
    iv. Ensure that there are resources for joint notification systems in place, so that CSBs are informed when their clientele become subject to arrest and incarceration.

3. Identify those current consumers of MH and SA services in the community who are at-risk for engaging in criminal conduct that is related to their disabled status.
    a. Local mental health agencies should work with the courts and jails in their locality to identify those consumers having histories of previous arrest and incarceration.
    b. Proper, confidential databases of these consumers should be maintained by the MH agency.
4. Assess current need for intensive, preventive outpatient services to those consumers who have been identified in this manner.
    a. Provide needed preventive services to existing consumer groups.
    b. Implement preventive service delivery to newly identified cases, following initial diversion or incarceration.

5. Implement all component elements of diversion program.

II: <u>Pretrial, Post-booking Diversion; Pretrial Evaluation and Treatment</u>: If booking and lockup are necessary, pretrial release to treatment may be possible. Models exist for diverting the target population from incarceration to mental health services after they have been booked and/or arraigned, such as the Chesterfield County Community Corrections/CSB Day Reporting Center partnership, deferred prosecution and other pretrial mental health court approaches, and the Henrico County Jail/CSB procedure for identifying consumers who may be eligible for admission to community hospitals while on bond.

Courts may order outpatient restoration to competency for defendants on bond. Early identification of detainees not eligible for bond or diversion programs who need mental health services can reduce the need for emergency hospitalization or inpatient restoration. Courts may order on-site restoration to competency for jail detainees. Only properly trained mental health personnel should provide competency restoration services in jails.

Detainees who are discharged to the jail following a court-ordered hospitalization require services to prevent hospital re-admission. The HPR-IV mobile jail team is one model of enhanced jail-based services. Detainees should only be admitted to the hospital under proper court order, but admission with minimum delay tends to shorten the length of stay. Civil hospitals that dedicate specific treatment teams to serving the misdemeanant and non-violent felony jail transfers also minimize length of stay, and tend to improve collaboration with jail-based service providers.

❖ ***Recommended actions:***

1. Implement all of the relevant underpinning aspects of stage I that are applicable. MOAs, etc. should be tailored to issues related to this stage in the criminal process.
2. Explore, through the auspices of the Department of Criminal Justice Services, local Community Criminal Justice Boards (CCJBs), local courts, the Office of the Executive Secretary of the Supreme Court of Virginia, the Office of the Attorney General, Commonwealth's Attorneys, and local P&P, development of a plan for the combined use of pretrial officers, CSB mental health staff, and other law enforcement or mental health staff to provide pretrial diversion-oriented consultation to the General District Courts, at bail hearings for appropriate cases, in the instance of nonviolent alleged offenses.
3. Use this stage in the process to raise issues of competency to stand trial, criminal responsibility and the need for inpatient "emergency" MH treatment.
4. Provide courts with options for deferred prosecution, with conditions related to active participation in appropriate mental health treatment imposed.
5. Consider referral to formal specialty mental health or drug courts.
6. Provide MH and SA treatment services, as outlined for sentenced jail inmates, in item IV, below. For those defendants who require pretrial incarceration, ensure that the jail has sufficient resources.

III: <u>Diversion at Trial</u>: Establishment and use of mental health court approaches to suspend convictions or sentences, conditional on compliance with mandated treatment. The implementation of the "mental health court" approach for the disposition of criminal matters involving defendants with mental illness and serious substance abuse disorders is gaining increasing acceptance around the United States. At least one Virginia locality (Norfolk) has begun a program of this type. Drug courts, an established approach for the adjudication of those with substance abuse disorders, have been in place in many jurisdictions in the U.S., and are currently operating in several Virginia locales. These alternative approaches offer great promise for reducing future risk of criminal behavior among those in this population, and for improving their access to adequate and restorative treatment.

❖ ***Recommended actions:***

1. Implement all of the relevant underpinning aspects of the preceding stages that are applicable. MOAs, etc. should be tailored to issues related to this stage in the criminal process.

2. Through the auspices of the DCJS, local CCJBs, local courts, the Office of the Executive Secretary of the Supreme Court of Virginia (OESSCV), the Office of the Attorney General, Commonwealth's Attorneys, and local P&P, explore development of a plan for the combined use of local P&P personnel, CSB mental health staff, and other law enforcement or mental health staff to implement either a specialized mental health court docket, or a "portable" mental health trial and case management procedure that:

    a. Enables the court to consider all the relevant medical (MH/SA) factors from a fully informed viewpoint.
    b. Provides for deferred sentencing, if the mentally ill defendant is convicted, with conditions of completing stipulated treatment, and maintaining appropriate safe compliance, imposed by the court.
    c. Includes procedures that allow the court to formulate and impose a sentence, when appropriate, that allows for conditional release to the community of the offender, with conditions for completing stipulated treatment, and maintaining appropriate compliance, imposed by the court.

IV: <u>Jail incarceration prior to or post-sentencing</u>: The full range of non-emergency mental health and substance abuse treatment services should be provided to defendants and convicted offenders requiring such treatment while in jail. The reported lack of access to needed MH and SA treatment in jail settings in the Commonwealth has prompted ongoing legislative review and action, since 2000. At issue, primarily, has been whether or not jail inmates are receiving state-of-the-art medical and psychosocial treatments, adequate group and individual rehabilitative services, and case management and discharge planning services, among other concerns. As many jail inmates with MH and SA treatment needs are not eligible for either community release or psychiatric hospitalization, there remains a pressing need in some locales for the full range of needed treatment services for this inmate group. The programs that are currently in operation in several Virginia jurisdictions, including Alexandria, Arlington, Fairfax and Henrico provide ready-made examples of the range of treatment services that should be available in all jails that house inmates for any longer than very brief incarceration episodes.

❖ ***Recommended actions:***

1. Implement all of the relevant underpinning aspects of the preceding stages that are applicable. MOAs, etc. should be tailored to issues related to this stage in the criminal process.
2. Through the combined efforts of the Secretary of Public Safety, the DCJS, the DMHMRSAS, the involved localities, the local CCJBs, the Virginia Sheriffs' Assn., the Virginia Assn. of Regional Jails, local CSBs, and offender support and advocacy groups, develop a plan for:
    a. Beginning release planning at the point of admission to the jail following sentencing.
    b. Providing the full array of jail-based mental health services, as defined in the *Blueprint for Contracting for Mental Health Services for Jail Detainees with Mental Illness* (Policy Research Associates, 1999) and in accord with the tenets of the *Mental Health Criminal Justice Consensus Project*, 2002).
    c. The programs of jail MH and SA services that are currently in place in localities such as Henrico, Fairfax, Arlington and Alexandria should be reviewed for this purpose.
    d. Ensure that a comprehensive set of necessary elements is provided for this purpose. This should include the use of an appropriate housing area in the jail, along with provision of proper psychiatry services, medication treatment, group and individual counseling, substance abuse treatment services, adequate case management and discharge planning services.
    e. Defining an optimal approach for determining those jail inmates who are truly in need of emergency hospitalization, and implementing a mutually agreeable path for securing that service for this group, whenever needed.
    f. Ensure that proper application for government entitlements have been made for all potentially eligible inmates, 3 months prior to release.
    g. Revise current facility/community Continuity of Care regulations with the DMHMRSAS and the CSBs, to include jail mental health program staff, and local community corrections personnel in the planning and post-incarceration placement process for incarcerated offenders. In developing this process, full consideration should be given to the DMHMRSAS/CSB Discharge Protocols approach to release planning.

V: <u>Community-release linkage</u>: When legal issues are resolved and detainees are to be released to the community, individuals in this group require additional access to many resources. These typically include: adequate financial support, activation of Medicaid or other sources of support, housing, access to immediate mental health services or residential substance abuse services (not a waiting list), and a comprehensive risk- and needs-based release plan developed prior to release.

❖ ***Recommended actions:***

1. Implement all of the relevant underpinning aspects of the preceding stages that are applicable. MOAs, etc. should be tailored to issues related to this stage in the process.
2. Implement, in conjunction with local CCJBs, DSS, CSBs, the courts, offender support and advocacy organizations, and local P&P, a comprehensive program of reentry treatment and supervision services that is consistent with current evidence-based standards.

3. Develop a discharge planning process for inmates needing treatment that conforms as closely as possible to the Continuity of Care Guidelines and Discharge Protocol procedures that are currently the basis for release planning for the DMHMRSAS and the Virginia CSBs.
4. For those mentally ill and substance abuse disordered offenders who are subject to probation upon release, establish joint release programs with local P&P and CSBs or other treatment providers that include incentives and sanctions for active participation or noncompliance with community treatment.
5. Integrate, where possible, reentering "state responsible" offenders in this process, and/or develop and implement a parallel approach for released offenders having such status.

General Recommendations:

1. **The DMHMRSAS and the work group should continue to work in concert with the Behavioral Healthcare Subcommittee of the General Assembly's Joint Commission on Health Care. This collaboration has been of great value in providing a legislative forum for the issues that are being addressed in the work group.**

2. **Continue to respond to the mandates of SJR 81, of the 2004 General Assembly, and related budget language requiring the DMHMRSAS to develop a web-based program for the sharing of innovative practices for the treatment of individuals with mental illness and substance abuse treatment needs, and to continue the activities of this work group. (Although the DMHMRSAS has recently implemented a web-based program of this type, additional follow-through work is needed in this area.)**

3. **Although much of the focus of the work group to date has been upon that group of offenders with primary mental illness or co-occurring disorders, the group is mindful that substance abuse among the offender population constitutes a key or overriding problem faced by all of the populations targeted by the work group agenda. It shall be necessary to devote serious time and consideration to developing recommended solutions to this significant aspect of our agenda, before the work of the group can be appropriately considered complete. Use of a modified version of the proposed General Treatment Model, outlined above, for addressing the treatment needs of those with primary and co-occurring substance abuse disorders may warrant further consideration.**

4. **Support implementation of the plan of recommended actions that has been submitted by the Juvenile Justice Subcommittee of the Child and Adolescent Special Populations Work Group, for juveniles having juvenile court involvement and mental illness or substance abuse disorders.**

5. **Via budgetary language and funding initiatives with the Virginia General Assembly, complete the following actions:**

    a. Provide directives to the Secretariat of Public Safety for the development of a model Community Policing curriculum for Crisis Intervention Training for law enforcement officers in all jurisdictions of the Commonwealth. Provide sufficient

resources to enable all Virginia law enforcement agencies, including jails, to participate in this training, once it has been developed.

b. Support in language and with resources the improved access of the courts in Virginia to the services of expert mental health evaluators, in accord with the recent requests of the Commissioner of the DMHMRSAS to the Office of the Executive Secretary of the Supreme Court of Virginia that reimbursement provided to expert evaluators for conducting community-based evaluations pursuant to the relevant sections of Chapters 11 and 11.1 of Title 19 of the *Code of Virginia.*
c. Direct the implementation of, and provide sufficient resources to develop a statewide cross-training program, developed through the DCJS, in all relevant areas of mental health and substance abuse assessment and treatment, geared toward law enforcement, jail personnel, court personnel, and mental health personnel having involvement with service delivery in the criminal justice system.
d. Direct the development of, and provide resources for implementing a joint VACSB/DMHMRSAS/law enforcement information sharing system by which CSBs in each jurisdiction may have access to local and regional arrest and booking information from law enforcement, so that each CSB may identify any active cases that have come under that active aegis of law enforcement, for purposes of service provision, and for consideration for referral to diversion activities in lieu of incarceration, where appropriate.
e. Endorse and direct the provision of renewable resources for the continuation of those model Virginia programs that are currently funded by temporary federal grants, or do not have a specified funding stream, such as the Montgomery County Crisis Intervention (CIT) program, the Chesterfield Day Reporting Center, and the Norfolk Mental Health Court.
f. Direct the DMHMRSAS and the Virginia CSBs to implement the community-based "outpatient" Restoration to Competency To Stand Trial program that has recently been developed on a statewide basis. Provide sufficient funding and other needed resources for each CSB to accomplish this goal.
g. Provide resources and budget language to develop pilot jail MH and SA services programs, based upon evidence-based approaches, for at least 3 Virginia jails that are currently limited by fiscal constraints from providing such services. Ensure that proper outcome studies are a part of each program.
h. Using a pilot program approach, provide resources and directives necessary for the development of additional mental health courts in the Commonwealth. Ensure that proper outcome studies are a part of each program. Explore expansion of drug courts, as well.
i. Provide resources necessary for the Secretariat of Public Safety and the Secretariat of Health and Human Resources to develop the means for the Department of Corrections, the DCJS, the Virginia Board of Compensation, and local and regional jails, in conjunction with the DMHMRSAS, to accurately depict the current population of inmates having serious medical illnesses, mental illness and substance abuse disorders in local, regional and state correctional facilities, and under the supervision of DOC Community Corrections and local offices of probation and parole. The Compensation Board should be provided with sufficient directives and resources to function as the lead agency with jails for this project, and for its continuing implementation. A statewide, HIPAA-

compliant and secure data collection system should be established for this purpose. Ensure that the features of this data system include information regarding current diagnoses, treatment plan information, and medication orders.

j. Allocate sufficient resources and provide directives to the Secretary of Public Safety and Health and Human Resources, the DOC, the Compensation Board, the VDH, and the DMHMRSAS to develop a statewide, multi-agency approach toward planning and providing a model pharmacy and drug formulary program that will ensure the use of "best practices" in selecting the range and types of medication to be used by medical providers in the jails and prisons of the Commonwealth.
k. Provide for the allocation of DMHMRSAS resources for the maintenance and upgrading of the Forensic Information Management System (FIMS).
l. Provide language and resources to adequately fund the array of juvenile and adult forensic evaluation training services that are necessary to ensure that there is an adequately trained group of forensic mental health evaluators available throughout the state to conduct court-ordered evaluations on an outpatient basis.
m. Direct and denote resources for the implementation by the DMHMRSAS of a comprehensive program for training mental health and criminal justice professionals and others in evidence-based, "best practices" approaches to the provision of community-based and facility-based mental health and substance abuse treatment modalities for individuals with criminal justice system involvement.

6. Change Virginia Medicaid regulations in the following ways:

a. In accord with recent directives from the U.S. Govt. Center for Medicare and Medicaid Services, Provide for "suspension", rather than "termination" of Medicaid benefits to recipients who are incarcerated in local and regional jails.
b. Alter Virginia Medicaid regulations to provide for reimbursement to providers of Substance Abuse treatment services to Medicaid recipients.

7. Foster the development of approaches that support the implementation of innovative practices at the grass roots level in Virginia communities. Recommended elements to be included in this approach include the following:

a. Use of a combination of statewide initiatives and a "local problems require local solutions" perspective, wherein the primary statewide efforts of the work group will be focused on the empowerment of groups of interested stakeholders in all of the jurisdictions of the Commonwealth.

b. The local Community Criminal Justices Services Boards (CCJBs) were identified as a key multi-agency decision making group to be approached by the work group for promoting a locality's investment in systems change for forensic clientele. These CCJBs should be actively consulted with, regarding the need for specialized court and law enforcement approaches for offenders with mental illness and substance abuse disorders in their localities.

c. Enabling the Forensic Work Group to serve as the primary consultative authority for the department with regard to the development and provision of training for these local boards, and other interested community groups.

d. The work group has endorsed, as valuable to the accomplishment of our mission, the use of state-of-the-art approaches to information sharing, such as video and computer-based training and instruction.

e. Exploring the availability of external funding for technical assistance and resource provision for the initiation and continuation of model diversion and intervention programs in the Commonwealth.

f. Develop and share a comprehensive set of data elements that can be used to target current and future service needs.

8. Provision of organizational and political support for the independent initiatives of several local jurisdictions, the CSBs, and the DMHMRSAS, such as: The HPR IV Jail Services Team, which will soon provide an array of psychiatric treatments to inmates in several jails in that health planning region.

9. Endorsement of the concept of designation of community psychiatric facilities as proper treatment sites for nonviolent criminal defendants in need of acute care.

10. Ensure the continued availability of community-based forensic evaluators by providing support and strengthening of the DMHMRSAS Forensic Evaluation Training Program with the UVA Institute of Law, Psychiatry and Public Policy.

11. Promote the successful adoption of the recommended changes requested of the Office of the Executive Secretary of the Supreme Court of Virginia (OESSCV) by DMHMRSAS Commissioner Reinhard, regarding forensic evaluations services, in his letter of July 6, 2004 to Secretary Baldwin. These recommendations include:

a. The implementation, by the OESSCV of a database system for itemized tallying, by Virginia Code section reference, of all community-based mental health evaluations of juvenile and adult trial competency, sanity at the time of offense, etc., as requested by the Chair of the Behavioral Healthcare Subcommittee of the Joint Commission on Health Care.
b. Increase the rates of reimbursement amounts cited in the *Chart of Allowances* for evaluations completed pursuant to §§ 19.2-175, 19.2-176 and 16.1-356 of the *Virginia Code*, to a standard rate of $400 per evaluation.
c. Development of separate, standard order forms for use by the courts when ordering evaluations of Competency to Stand Trial (19.2-169.1) and Sanity at the time of the Offense, requested by the defense (19.2-169.5), or by the Commonwealth (19.2-168), to replace the current, combined standard form (DC-342).
d. The provision of reimbursement for juvenile (§ 16.1-356) and adult (§ 19.2-169.1) competency to stand trial evaluations that are completed pursuant to a new

court order written for the same case, provided that there is a legitimate basis for reassessment of a defendant's trial competency.

12. **DMHMRSAS psychiatric hospitals should continue to develop procedures for completing outpatient evaluations for the courts, and continue to work with the criminal courts to divert evaluations to community providers, wherever appropriate.**

13. **Encourage the review and appropriate modification of DMHMRSAS inpatient programs for individuals found "NGRI" or "URIST", as well as "mandatory parolees".**

14. **Consult with the Virginia Board of Corrections regarding the need to expand upon the current mental health standards set by that body for local and regional jails, in § 6VAC15-40-1010 of the *Virginia Administrative Code*.**

15. **Integrate the activities of the Governor's NGA Policy Team for Prisoner Reentry with this work group process, as feasible.**

16. **Continue to identify and recommend all necessary changes in these areas that shall be required to implement each programmatic goal of the work group:**

    a. Funding/resource allocation needs
    b. Local/State policy changes
    c. Memoranda of Agreement for designated activities
    d. Changes in the Code of Virginia
    e. Changes in Virginia Administrative Regulations
    f. Licensure/certification procedures needed
    g. Human rights procedural guarantees

It is heartening and encouraging that many of the initial goals discussed in 2003 by the Forensic Special Populations Work Group have already been realized, in whole or in part. At the time of the initial convening of the group, the DMHMRSAS was seriously challenged by a rate of court orders for inpatient treatment of offenders that exceeded the ready capacity of DMHMRSAS facilities to admit jail inmates in a timely manner, resulting in prolonged waits for admission at two state hospitals (Central State Hospital and Eastern State Hospital) for criminal defendants requiring evaluation or treatment to restore competency to stand trial. Today, the waiting lists for admission to either of those facilities have been reduced substantially, due to the implementation of programmatic changes there, such as completion of a greater number of court-ordered evaluations at Central State Hospital on an "outpatient", one-day basis, the use of improved utilization of hospital bed space at each facility, and the improved coordination of hospital admissions with the local and regional jails from which these admissions are sent.

Similar progress has been made in other areas of early work group focus, as well. The Jail Services Team program that was developed by the CSBs of Health Planning Region IV is nearing full implementation; the DMHMRSAS and the CSBs have jointly developed and published an adult Restoration to Competency to Stand Trial Manual, and have provided training

in the provision of community-based restoration services to personnel from all, or nearly all the Virginia CSBs.

The first mental health court in Virginia, conceived and developed by one of our members, in the Norfolk Circuit Court, was placed in operation after the start of this work group. The DMHMRSAS, in conjunction with the University of Virginia Institute of Law, Psychiatry and Public Policy (ILPPP), has established, in accordance with the directives of the Behavioral Healthcare Subcommittee, the first website in the Commonwealth that is devoted solely to the purpose of sharing of innovative, promising practices in the area of service provision with those having dual status as individuals with mental illness and substance abuse disorders and active involvement with the Virginia criminal justice system.

The DMHMRSAS and the OESSCV, in responding to another directive of the Behavioral Healthcare Subcommittee have, in consultation with the ILPPP, made significant progress toward developing a means for determining an accurate count of the number of community-based forensic evaluations that have been paid for by the OESSCV. This information is essential for statewide planning for forensic training and service delivery for the courts of the Commonwealth. Additionally, and also in response to the directives of the Behavioral Healthcare Subcommittee, and of the Governor's NGA Prisoner Reentry Policy Team, the DMHMRSAS, the Virginia DOC, and the Virginia Association of Community Services Boards (VACSB) are nearing completion on the development of a joint Memorandum of Understanding, aimed at facilitating the access of offenders who have been committed to the DOC to community-based mental health and substance abuse treatment services, or inpatient state hospital treatment (when necessary) upon their release to the community, on probation or parole.

The work group membership is also pleased that those members who have had direct involvement with the innovative diversion and jail programs in Virginia have developed a series of informative presentations regarding their programs. It is planned that this presentation series will be offered to Community Criminal Justice Boards and other local policy-making bodies throughout the state, with the goal of generating interest in the themes addressed by the work group. Members have already offered presentations to a joint meeting of the Prisoner Reentry Policy Team, and will be reviewing their programs at the August and October sessions of the Behavioral Healthcare Subcommittee.

Much progress has been made toward improving the access to treatment for juveniles and adults with mental illness and serious substance abuse disorders having involvement in the Virginia criminal courts, during the past year. The membership of the Forensic Special Populations Work Group is proud that many in our group have had responsibility for these improvements. We are also pleased that the results of our collective effort have yielded the comprehensive set of findings and recommendations provided for this report. It has also been our collective consensus, at the juncture occasioned by the submission of this report, that much remains to be accomplished before our mission will have been completed.

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